Medication Log

Child's Name: _____ Date:_____

Medication Name:_____ Dose:_____

Time(s):_____, _____ Date Given: _____

Parent /Guardian Name:_____

Parent/Guardian Signature:_____

Medication Name: _____ Date: _____

Time(s): _____, _____ Verified Meds: _____ Dosage Given: _____,_____

Teacher Signature: _____

Parent Called: Yes or No Time: _____ Teacher Initials:_____ Parent Initials: _____

Comments:

_____
_____
_____
_____
_____
_____
_____

- *Medication prescribed by a doctor **must** be in the original bottle/box in order receive medication from BLM staff.*
- *Over the counter medication **must** be kept in the original box in order to receive medication from BLM staff.*